



Anatomical (Whole Body) Donation Registration

To be completed by body donor: Please provide the following information to register with our program. This allows us to collect your wishes in advance so that your intentions may be honored within the program. This information may also be used to complete the Tennessee Death Certificate. Should you wish to change any information after submission of this form, please contact the ADP Program Coordinator (programcoordinator.adp@vumc.org or 615-322-7948). Otherwise, the program will rely on the information you have provided herein.

Complete legal name (first, middle, last, suffix): _____

Date of birth (M/D/Y): ____/____/____ Place of birth (city and state, or foreign country): _____

Primary phone number: (____) _____ Alternate phone number: (____) _____

Social Security Number: _____ - _____ - _____ Email: _____

Have you ever been in the Armed Forces? ☐ Yes ☐ No Gender at birth: ☐ Male ☐ Female

Residence address (must reside in Tennessee to register): _____

Residence county: _____

Current marital status: ☐ Married ☐ Divorced ☐ Married, but separated ☐ Never married ☐ Widowed

If married, provide spouse's full name (if wife, maiden name): _____

Father's name (first, middle, last): _____

Mother's birth name (first, middle, last): _____

Usual occupation before retirement: _____ Business or industry: _____

Education level: ☐ 8th grade or less ☐ Bachelor's degree (e.g., BA, AB, BS)
☐ 9th - 12th grade; no diploma ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
☐ High School graduate or GED completed ☐ Doctorate (e.g., PhD, EdD) or Professional degree
☐ Some college credit, but no degree (e.g., MD, DDS, DVM, LLB, JD)
☐ Associate degree (e.g., AA, AS) ☐ Unknown

Hispanic origin: ☐ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican ☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino ☐ Unknown
Please specify _____

Race: ☐ White ☐ Japanese ☐ Samoan
☐ Black or African American ☐ Korean ☐ Other Pacific Islander
☐ American Indian or Alaska Native ☐ Vietnamese ☐ Specify _____
Name of tribe _____ ☐ Other Asian ☐ Other ☐ Specify _____
☐ Asian Indian ☐ Specify _____ ☐ Unknown
☐ Chinese ☐ Native Hawaiian ☐ Prefer not to answer
☐ Filipino ☐ Guamanian or Chamorro

Not Part of Medical Record – Do Not Scan

Anatomical Donation Medical History

Please check any of your medical conditions that apply and provide as much detail below, including dates, if possible.

Specify any other conditions not listed that may be related to surgery, disease, or an accident.

If your medical conditions were treated at Vanderbilt, we will still need the information here for our files.

- | | | |
|--|---|---|
| ☐ Chronic obstructive pulmonary disease (emphysema) | Surgery | ☐ Orthopedic surgery (specify below) |
| ☐ Cancer (specify type below) | ☐ Hysterectomy | ☐ Trauma surgery (specify below) |
| ☐ Heart disease (specify below) | ☐ Prostatectomy | ☐ Amputation (specify below) |
| ☐ Congenital variation (specify below) | ☐ Knee | ☐ Appendix |
| ☐ Other (specify below) | ☐ Shoulder | ☐ Gall bladder |
| Implanted devices | ☐ Hip | ☐ Splenectomy |
| ☐ Joint replacement (specify below) | ☐ Heart | ☐ Colon resection |
| ☐ Pacemaker | ☐ Vascular surgery (specify below) | ☐ Gastric bypass |
| ☐ Venous Port | | |

Please specify, using additional paper if needed _____

Please note, some rarely occurring conditions can prevent acceptance at time of death, including but not limited to: morbid obesity, infectious disease, open wounds or the program is at capacity.

The requested information is necessary to complete the Certificate of Death as required by Tennessee state law and to match your donation with the most appropriate academic experience. Your personal health information will remain confidential within our program according to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Anatomical Donation Disposition Directive

Upon conclusion of educational use of my anatomic donation for the advancement of knowledge, training, skill acquisition, skill refinement, and/or research, any remains will be cremated. We will return the ashes or bury them in our community garden, as you direct. Please indicate your / your family's preference (choose one):

- ☐ Pick-up: Expected for residents of Davidson County or adjacent Counties
- ☐ Mail: Outside of the Metropolitan Nashville Area
- ☐ Bury: Please inter my ashes in Vanderbilt Community Garden at Woodlawn Memorial Park, Nashville, TN, USA

For notification of cremation, pick-up, and/or mailing of ashes:

Please provide the full name, address, phone number, and email address of the individual or institution to whom my ashes should be returned (primary and secondary, if applicable; or state 'None'):

Primary: _____
Full Name Address Phone Number Email

Secondary: _____
Full Name Address Phone Number Email

VANDERBILT HEALTH

Uniform Donor Registration

In the hope that I may help others, I hereby make this anatomical gift, if medically acceptable, to take effect upon my death I authorize and direct the administrator of my estate, next of kin, or other person designated to handle my affairs following my death to communicate with the Vanderbilt Anatomical Donation Program to facilitate the handling and transportation of my body after death. I also authorize the Vanderbilt Anatomical Donation Program to collect pertinent health information at the time of my death, per HIPAA 45 C.F.R. §164.512.

I voluntarily desire to donate my whole body for anatomical study for educational purposes including advancement of knowledge, training, skill acquisition, skill refinement, and/or research as determined by the program.

I understand that my medical information or any images or recordings related to my donation may be used for educational purposes including advancement of knowledge, training, skill acquisition, skill refinement, and/or research and will be handled in compliance with HIPAA and other privacy laws.

I understand that upon conclusion of educational use of my anatomic donation for the advancement of knowledge, training, skill acquisition, skill refinement, and/or research, any remaining material will be cremated.

I understand and agree that it is my sole responsibility to notify the Anatomical Donation Program (ADP) of any change in my marital status and/or the names of the individual(s) designated to be notified and receive my ashes. If I fail to do so, I understand and agree that the ADP will follow my wishes as stated in this document.

I understand that if the individual or institution to whom I designate declines or fails to pick-up my ashes, my ashes will be held for a period of 18-months from the date of cremation and then buried in the Vanderbilt Community Garden at Woodlawn Memorial Park, Nashville, TN, USA.

Printed full name of donor: _____

Signature of donor: _____

Date & Time: _____

First witness (printed name and signature): _____

Second witness (printed name and signature): _____

This is a legal document under the Uniform Anatomical Gift Act or similar laws. Registration will not be complete unless all sections are filled out, signed, witnessed, and returned to our office. Upon receipt of your enrollment forms and following a thirty (30) day waiting period, you will receive a letter of confirmation and a donor card for your files.

Please mail completed forms to:
Vanderbilt Health Anatomical Donation
Program 2213 Garland Ave
MRB IV 3450
Nashville, TN 37232 -0480

OR

Fax all completed forms to: (615) 322-8441

For questions:
Telephone: (615) 322-7948 Ext 1
Email: programcoordinator.adp@vumc.org
Office location:
3450 Medical Research Building IV
Nashville, TN 37232